STATE OF MARYLAND - DEPARTMENT OF BUDGET AND MANAGEMENT

RETIREE YEAR 2004 WORKSHEET

PERSONAL DATA - RETIREE INFORMATION ONLY

Name:
Address:
City **State** **Zip Code**

Sex: ○ **Male** ○ **Female**

MARITAL STATUS:
S ○ Single W ○ Widowed
M ○ Married D ○ Divorced
L ○ Separated

Phone: ( ) __ __ __ - __ __ __ __

Date of Birth: ____/____/_____

Social Security Number: __ __ __ /__ __ / __ __ __ __

My Status:
○ I am the Retiree
○ I am the Beneficiary of a Deceased Retiree. My relationship to the deceased retiree was:
○ Spouse ○ Other, describe: _____
○ Child

Is your address correct? If not, please correct below.

ADDRESS CORRECTION:

Street

Apt #

City **State** **Zip Code**

ENROLLMENT/CHANGE REQUESTED

○ Open Enrollment
○ New Retiree, Date of retirement:_____
○ New Beneficiary of Deceased Retiree; Date of Retiree's death:_____
○ Change in enrollment:
○ Add spouse/dependent because of:
○ Marriage, Date:_____
○ Birth/Adoption/Appointed permanent legal guardian, Date:_____
○ Other:_____
○ Cancel all coverage, explain: _____
○ Remove spouse/ dependent because of:
○ Divorce/Limited Divorce, Date:_____
○ Death* of: _____ Date:_____
*(*Attach copy of Death Certificate to this form.)*
○ Dependent no longer eligible due to overage, marriage, etc., Date:_____
○ Change coverage because Medicare eligible
(Fill in Medicare information in *Medicare Information* section)
○ Other Change:_____

Dependent Information *PLEASE PRINT - DEPENDENTS INCLUDE YOUR SPOUSE AND CHILDREN*

THE FOLLOWING IS RESERVED FOR DEPENDENT INFORMATION. PLEASE MAKE ANY CHANGES TO YOUR DEPENDENT FILE BELOW. YOU MAY USE THIS SECTION FOR ADDITIONS (A), CHANGES (C) OR DELETIONS (D) TO YOUR EXISTING HEALTH BENEFITS FILE. PLEASE PRINT. COMPLETE ALL INFORMATION IF AN ENTRY IS MADE. PRINT CLEARLY. NOTE: DEPENDENTS MUST BE DEPENDENTS OF THE ORIGINAL RETIREE.

A/ C/D	*DC*	*LAST NAME*	*FIRST NAME*	*MI*	*SEX*	*BIRTH DATE*	*RELATION-SHIP*	*SOCIAL SECURITY NO.*	*COVER THIS DEPENDENT FOR: HEALTH*	*DRUG*	*DENTAL*

** If you are adding a dependent, verification is required. Please see your Benefits Booklet for dependent documentation requirements. Dependent children over age 19 must be full-time students or disabled. Students over age 25 are not eligible.*

ENROLLMENT FOR YEAR 2004

E N R O L L M E N T W O R K S H E E T

Medical Benefits

Choose one Option:
OPTIONS
- ○ New Enrollment or Change in Plan
- ○ Addition or removal of a dependent
- ○ No, I do not want to start this benefit
- ○ Cancel all medical benefits coverage
- ○ Change due to Medicare eligibility

Select One Coverage Level for yourself and eligible dependents.
COVERAGE LEVEL
1. ○ Retiree Only, NO Medicare
2. ○ Retiree & Child, NO Medicare
3. ○ Retiree & Spouse, NO Medicare
4. ○ Retiree & Two or More, NO Medicare
5. ○ Retiree only, WITH Medicare Parts A&B
6. ○ Retiree & One, One WITH Medicare Parts A&B
7. ○ Retiree & One, Both WITH Medicare Parts A&B
8. ○ Retiree & Two, One WITH Medicare Parts A&B
9. ○ Retiree & Two, Two WITH Medicare Parts A&B
10. ○ Retiree& Two or More, All WITH Medicare Parts A&B
11. ○ Retiree & Three or More; One, Two or Three WITH Medicare Parts A&B

PPO Plans
- ○ BC/BS PPO
- ○ MLH Eagle PPO

POS Plans
- ○ Aetna POS
- ○ BC/BS MD POS
- ○ MD IPA Preferred POS

HMO Plans
- ○ BlueChoice HMO
- ○ Kaiser HMO
- ○ Optimum Choice HMO

VISION BENEFITS **ARE INCLUDED** UNDER ALL MEDICAL PLANS. CONTACT YOUR MEDICAL PLAN FOR VISION SERVICES.
PRESCRIPTION DRUG AND DENTAL COVERAGE **ARE NOT** INCLUDED IN ANY MEDICAL PLAN.

Medicare Information

*If you, your spouse or another dependent are 65 or older, or are eligible for Medicare as a result of disability, you must complete this section. State Health Plan regulations require that you be placed in a Medicare supplemental coverage level as soon as you are 65 or are eligible for Medicare as a result of a disability. You must carry **both** parts A and B of Medicare (Hospital and Medical) or you will be required to pay for medical costs which Medicare would have covered.*

NAME	*MEDICARE NUMBER*	*HOSPITAL INSURANCE (Part A) EFFECTIVE DATE*	*MEDICAL INSURANCE (Part B) EFFECTIVE DATE*
Retiree			
Spouse			
Other Dependents (specify)			

Prescription Drug

Choose one Option:
OPTIONS
- ○ New enrollment
- ○ Addition or removal of a dependent
- ○ No, I do not want to start this benefit
- ○ Cancel all coverage

Select One Coverage Level for yourself and eligible dependents.
COVERAGE LEVEL
- ○ Retiree only
- ○ Retiree plus one child; specify_____
- ○ Retiree plus spouse
- ○ Retiree plus two or more people

NOTE: Prescription Drug is NOT included in any health plan. You must be enrolled in the Prescription Drug Plan if you want this benefit.

Dental

Choose one Option:
- ○ New enrollment
- ○ Addition or removal of a dependent
- ○ No, I do not want to start this benefit
- ○ Cancel all coverage

Choose One Plan
- ○ Dental Benefits Providers DHMO

Or
- ○ United Concordia DHMO

Or
- ○ United Concordia POS

Choose One Coverage Level
- ○ Retiree only
- ○ Retiree plus one child; specify_____
- ○ Retiree plus spouse
- ○ Retiree plus two or more people

NOTE: Dental is not included in any Medical Plan. *You must be enrolled in a Dental Plan if you want this benefit.*

ENROLLMENT FOR YEAR 2004

E N R O L L M E N T W O R K S H E E T

Life Insurance

THIS COVERAGE APPLIES TO PERSONS WHO WERE ACTIVELY EMPLOYED ON OR AFTER JANUARY 1, 1995 AND WHO HAD LIFE INSURANCE AT THE TIME OF RETIREMENT.

RETIREE

MARK ONE:

○ I want to continue enrollment in Life Insurance. (Make a $ selection at right for the amount you want to continue).	○ $ 10,000	○ $ 20,000	○ $ 30,000	○ $ 40,000	○ $ 50,000
	○ $ 60,000	○ $ 110,000	○ $ 160,000	○ $ 210,000	○ $ 260,000
○ I want to continue enrollment in Life Insurance but at a reduced level. (Make a $ selection at right).	○ $ 70,000	○ $ 120,000	○ $ 170,000	○ $ 220,000	○ $ 270,000
	○ $ 80,000	○ $ 130,000	○ $ 180,000	○ $ 230,000	○ $ 280,000
○ I want to **cancel** Life Insurance. (I understand, once cancelled, I may not re-enroll).	○ $ 90,000	○ $ 140,000	○ $ 190,000	○ $ 240,000	○ $ 290,000
	○ $ 100,000	○ $ 150,000	○ $ 200,000	○ $ 250,000	○ $ 300,000

SPOUSE

Up to 1/2 of the amount selected for retiree

○ Having continued Life Insurance for myself as a retiree, I want to continue Life Insurance on my spouse. (Make a $ selection at right).	○ $ 5,000	○ $ 10,000	○ $ 15,000	○ $ 20,000	○ $ 25,000
○ Having continued Life Insurance for myself as a retiree, I want to continue Life Insurance on my spouse but at a reduced level. (Make a $ selection at right).	○ $ 30,000	○ $ 55,000	○ $ 80,000	○ $ 105,000	○ $ 130,000
	○ $ 35,000	○ $ 60,000	○ $ 85,000	○ $ 110,000	○ $ 135,000
○ **Cancel** Life Insurance on my spouse. (Once cancelled, cannot re-enroll).	○ $ 40,000	○ $ 65,000	○ $ 90,000	○ $ 115,000	○ $ 140,000
	○ $ 45,000	○ $ 70,000	○ $ 95,000	○ $ 120,000	○ $ 145,000
	○ $ 50,000	○ $ 75,000	○ $ 100,000	○ $ 125,000	○ $ 150,000

CHILDREN

Up to 1/2 of the amount selected for retiree

○ Having continued Life Insurance for myself as a retiree, I want to continue Life Insurance on my dependent child(ren). (Make a $ selection at right).	○ $ 5,000	○ $ 10,000	○ $ 15,000	○ $ 20,000	○ $ 25,000
○ Having continued Life Insurance for myself as a retiree, I want to continue Life Insurance on my dependent child(ren) but at a reduced level. (Make a $ selection at right).	○ $ 30,000	○ $ 55,000	○ $ 80,000	○ $ 105,000	○ $ 130,000
	○ $ 35,000	○ $ 60,000	○ $ 85,000	○ $ 110,000	○ $ 135,000
	○ $ 40,000	○ $ 65,000	○ $ 90,000	○ $ 115,000	○ $ 140,000
○ **Cancel** Life Insurance on my dependent child(ren). (Once cancelled, cannot re-enroll).	○ $ 45,000	○ $ 70,000	○ $ 95,000	○ $ 120,000	○ $ 145,000
	○ $ 50,000	○ $ 75,000	○ $ 100,000	○ $ 125,000	○ $ 150,000

Employee Signature

Please enroll me for the Benefits indicated on this form. I understand the benefits and limitations provided by the various plans, and I authorize the State of Maryland to make the necessary adjustments in my retirement allowance based on the choices I have made. To the extent deemed necessary by the Plan Administrator for the proper administration of my coverages, I authorize the release of all medical records and related information pertaining to me or to my dependents to the benefit plans. The personal information provided on this enrollment form is complete, accurate, and in accordance with the Department of Budget and Management regulations. I understand that I cannot cancel or change my enrollment except during an Open Enrollment period or as a result of a change in my family status.

I understand that the Benefit Program offered by the State is subject to modifications and changes and that the benefits I have chosen in this enrollment are only in effect for calendar year 2004. The State of Maryland reserves the right to modify any of the benefits provided and give no assurances, expressed or implied, that any coverage obtained hereunder will continue beyond calendar year 2004.

I understand that enrollment in benefits to which I am not entitled is considered fraud. In all cases I am responsible for the accuracy of my benefits, coverage levels and deductions. I further understand that if I willfully misrepresent the eligibility of myself or my dependents on my health benefits application, or fail to take the necessary action to remove ineligible dependents, or any way obtain benefits to which I am not entitled, my benefits will be cancelled and I will be required to repay any claims and/or insurance premiums. I understand that I can only change my selected benefits due to a qualifying event or during Open Enrollment.

FURTHER, in accordance with Department requirements and regulations, I hereby certify that child(ren) listed on my coverage are my natural child(ren), adoptive child(ren), legal wards, OR that stepchild(ren) or grandchild(ren) listed above are living with me and I provide at least 50% of their support I further certify that if I have listed a spouse, we have been joined in marriage in a ceremony recognized by the laws of the State of Maryland. (Verification of the foregoing is required.)

If you have any questions concerning the benefits and services that are provided by or excluded under this agreement, please contact The Employee Benefits Division before signing this application.

Other than Medicare and your State of Maryland Benefits, do you, your spouse, or any of your dependents have other health insurance? ○ Yes ○ No

Specify Who is covered, Name of Insurance Company and Policy Number:_____

X _____ Retiree Signature

_____/_____/_____ Date

(_____) _____ Work Phone Number (Ext.)

(_____) _____ Your Home Phone Number

COMPLETED AND SIGNED ENROLLMENT FORMS SHOULD BE MAILED OR HAND-DELIVERED TO:

Employee Benefits Division
301 W. Preston Street
Room 510
Baltimore, Maryland 21201

Please mail in an envelope.
Please do not staple or tape.